Health Insurance Billing Consent Form

Health Insurance:____________________________________

Benefits Phone Number:_____________________________

Patient's Name:________________________________ Member ID#_____________

Patient's birth date:_________________ Phone:_____________________________

Patient's address:____

Physician:_________________________Phone:_____________________________

Sponsor's Name:_____________________________ Date of Birth:_______________

Sponsor's Address:____

Sponsor's Phone:_____________________ Employer:_________________________

Insured's Policy group Number:_______________________Member ID:___________

Other Insurance____

I consent to necessary examination procedures and/or treatment for my child by Way to Grow, LLC staff.

I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to Way to Grow LLC, for services provided and claimed.

Parent Signature:__________________________________Date:____________

I have been given a copy of Way to Grow, LLC's Notice of Privacy Practices, will review it and keep it on file.

Signature:____